CHAPTER 13 MEDICAID PROGRAM: ADMINISTRATIVE PROCEDURES

1300 GENERAL PROVISIONS

1300.1 This chapter governs the administrative actions the Department may take with respect to providers who participate in the District of Columbia Medicaid Program. The administrative actions are as follows:

(a) Exclusion, termination and/or suspension of a provider from the program;

(b) Suspension of payments, in whole or in part, to recover or aid in the recovery of overpayments to a provider;

(c) Suspension of payments, in whole or in part, to aid in determining if overpayments have been made to a provider or if a program payment is correct;

(d) Determination by the Department of Human Services (DHS) of program reimbursement on the basis of cost reports filed by a provider;

(e) Requests for reinstatement by a provider in the program; and

(f) Procedures to appeal actions taken under this subsection.

1300.2 This chapter shall be construed in conjunction with Title XIX of the Social Security Act, applicable federal regulations, pertinent District laws, regulations governing the District's Medicaid program pursuant to §1-359, D.C. Code, 1981 ed., and the District of Columbia Office of Health Care Financing Provider Manual.

1300.3 This chapter shall not apply if the Department of Human Services does not reimburse a facility due to lack of certification.

1301 EXCLUSION OF MEDICAID PROVIDER FROM REIMBURSEMENT

1301.1 For purposes of this chapter, "exclusion" means that items or services furnished by a specific provider who has defrauded or abused the Medicaid Program shall not be reimbursed under Medicaid.

1301.2 The Director shall exclude a provider from Medicaid reimbursement if he or she has done any one (1) of the following:

(a) Knowingly and willfully made or caused to be made any false statement or misrepresentation of material fact in claiming, or in determining the right to, payment under Medicaid;

(b) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for health care;

(c) Submitted or caused to be submitted to the Medicaid Program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(d) Engaged in Medicaid Program abuse or fraud as defined in §1399 of this chapter.

1301.3 The activities in §1301.2 may be used as a basis to terminate a provider agreement under §1302 of this chapter.

1301.4 The Director may base his or her determination that services were excessive or of unacceptable quality on reports, including sanction reports, from any or all of the following sources:

(a) The Professional Standard Review Organization for the area served by the provider;

(b) District, State or local licensing or certification authorities;

(c) Peer review committee or fiscal agents or contractors;

(d) District, State or local professional societies; and

(e) Other sources deemed appropriate by the Director or Health Care Financing Administration (HCFA).

1302 TERMINATION OF MEDICAID PROVIDER AGREEMENT

1302.1 The Director may terminate a provider agreement under Medicaid if he or she determines that at any time prior to or after the effective date of these rules, the provider has done any one (1) of the following:

(a) He or she engaged in any activity listed in §1301 regarding fraud or abuse;

(b) Is not currently licensed and registered and/or certified as required by the law of the jurisdiction in which he or she practices;

(c) Did not comply substantially with the provisions of Title XIX or with provisions of the provider agreement and pertinent District laws and regulations;

(d) Failed to furnish requested information that the Director has found necessary for a determination as to whether payments are or were due under Medicaid and the amounts due;

(e) Refused to permit a requested examination of its fiscal or other records by or on behalf of DHS or HCFA, as necessary, for verification of information furnished as a basis for payment under Medicare;

(f) Had disciplinary action against him or her entered on the records of the State or District licensing or certifying agency;

(g) Had his or her controlled drug licenses withdrawn;

(h) Falsified information related to a request for payment;

(i) Repeatedly claimed District Medicaid reimbursement for services provided to individuals who have borrowed or stolen District of Columbia Medicaid Identification Cards as proof of eligibility; or

(j) Has been suspended or excluded from Medicare or convicted of a program-related offense, in a Federal, State, or District of Columbia Court.

1303 NOTICE OF PROPOSED EXCLUSION OR TERMINATION

1303.1 If the Director proposes to deny reimbursement to a provider under §1301 or to terminate a provider agreement pursuant to §1302, he or she shall send written notice of intent and the reasons for the proposed exclusion or termination to the provider. The notice shall include the following:

(a) The basis for the proposed action;

(b) The specific action the Director intends to take;

(c) The provider's right to dispute the allegations and to submit evidence to support his or her position; and

(d) Specific reference to the particular sections of the statutes, rules, provider's manual, and/or provider's agreement involved.

1303.2 Within thirty (30) days of the date on the notice, the provider may submit documentary evidence and written argument against the proposed action.

1303.3 For good cause shown, the Director may extend the thirty (30) day period prescribed in §1303.2.

1303.4 If the Director decides to exclude the provider under §1301 or terminate the provider agreement under §1302 after the provider has filed a response under §1303.2, then the Director shall send written notice of his or her decision to the affected party at least fifteen (15) days before the decision becomes effective. The notice shall include the following:

(a) The reasons for the decisions;

(b) The effective date of the termination or exclusion;

(c) The extent of the applicability to participation in the District's Medicaid Program;

(d) The earliest date on which the Director shall accept a request for reinstatement determined in accordance with §1315.2;

(e) The requirements and procedures for reinstatement in the District's Medicaid Program; and

(f) The provider's right to request a hearing by filing a notice of appeal with the D.C. Board of Appeals and Review.

1303.5 If the provider files a notice of appeal within fifteen (15) days of the date of the notice of termination or exclusion, then the effective date of the proposed action shall be stayed pending a decision following final action by the D.C. Board of Appeals and Review.

1303 NOTICE OF PROPOSED EXCLUSION OR TERMINATION

1303.6 Except as provided in §1303.8 and §1303.9, a provider who has been excluded or terminated from the District's Medicaid Program shall be precluded from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association, for any health care provided under the Medicaid Program after the effective date of the exclusion or termination.

1303.7 If the provider has been excluded or terminated from participation in the Medicare Program or otherwise sanctioned because of fraud or abuse under that program, the effective date of denial of payment for services or termination from the District's Medicaid Program shall be the effective date of exclusion from the Medicare Program as established by HCFA.

1303.8 Medicaid payments shall be made for inpatient services furnished in a hospital, skilled nursing facility or intermediate care facility to a recipient who was admitted before the effective date of the Medicare exclusion for up to thirty (30) days after the date of the Medicare exclusion.

1303.9 Payment for home health services furnished under a plan established before the effective date of the exclusion shall be available to the extent federal financial participation is available under the federal regulation.

1304 SUSPENSION FOR CONVICTION OF PROGRAM RELATED OFFENSE

1304.1 For the purposes of this section, the term "suspension" means that items or services furnished by a specified provider who has been convicted of a program related offense in a Federal, District of Columbia, State or local court shall not be reimbursed under Medicaid.

1304.2 The Director shall, in accordance with 42 CFR 455.210, suspend from the District's Medicaid Program any party who has been suspended from participation in Medicare for conviction of a program-related crime.

1304.3 The Director shall suspend any convicted party who is not eligible to participate in Medicare whenever HCFA directs the Director to take the action.

1304.4 Any suspension imposed by the Director under §1304.3 shall, at a minimum, be effective on the date and for the period specified by HCFA.

1304 SUSPENSION FOR CONVICTION OF PROGRAM RELATED OFFENSE
(Continued)

1304.5 Except as authorized by federal regulations, reimbursement for services furnished directly or under the supervision of a suspended party shall not be made during the period of suspension.

1304.6 Nothing in §1304.4 shall prevent the Director from imposing other sanctions against the provider under these rules.

1304.7 If the Director proposes to terminate the provider agreement or to suspend the provider for a period of greater duration than that specified by HCFA, then prior to taking the action, the Director shall follow the procedures specified for exclusion and termination actions as set forth in §1303.

1304.8 If the Director's suspension is effective on the date and for the period specified by HCFA, then the convicted party shall be notified in writing by the Director regarding the effective date for the suspension.

1304.9 The party shall not be entitled to a hearing under this chapter with regard to the suspension by HCFA. In this case, any right to appeal shall be provided by HCFA, not by the Director.

1305 SUSPENSION OF MEDICAID PAYMENTS FOR OVERPAYMENTS

1305.1 Payments otherwise authorized to be made to a provider under the District of Columbia Medicaid Program may be suspended, in whole or in part, by the Director when either of the following occurs:

(a) The Director has detemined that the provider to whom the payments are to be made has been overpaid under Title XIX of the Social Security Act or pertinent federal or District laws and regulations; or

(b) DHS has reliable evidence that overpayment exists; however, additional evidence may be needed for a determination.

1305.2 A suspension shall be put into effect only after the provisions in §1305 through §1308 have been complied with and the Director has determined that the suspension of payments in whole or in part, is needed to protect the program against financial loss.

1305.3 The suspension shall be used to recover or aid in the recovery of overpayments that have been made to the provider.

1306 SUSPENSION OF MEDICAID PAYMENTS FOR OVERPAYMENT-PROCEEDING

1306.1 Whenever the Director has determined that a suspension of payments under §1305 shall be put into effect with respect to a provider, the Director shall notify the provider of his or her intention to suspend payments, in whole or in part, and the reasons for making the suspension.

1306.2 If the reason for suspending payments is that the Director has determined that the provider has been overpaid and the suspension is needed to aid in recovery, the notice to the provider under §1306.1 shall include the following:

(a) The factual basis for the determination of overpayments including the dollar value of the overpayment;

(b) How the overpayment was computed; and

(c) Specific reference to the particular sections of the statutes, rules, provider's manual and/or provider's agreement involved.

1306.3 If the reason for the intended suspension is that the Director has reliable evidence that the provider has been overpaid, the notice to the provider shall include the following:

(a) The reasons for making the suspension; and

(b) Any actions the Director intends to take to determine if any overpayment has been made.

1306.4 Within thirty (30) days of the date in which the notice is sent to the provider under this section, the provider may submit documentary evidence and written argument against the proposed action.

1306.5 For good cause shown, the Director may extend the thirty (30) day period.

1306.6 If no statement is received from the provider within the thirty (30) day period or the additional thirty (30) day period specified in the notice, the suspension shall go into effect on the date after the end of the period.

1306.7 The provisions of this section shall not apply when the Director, after furnishing a provider a written notice of the amount of the program reimbursement pursuant to §1309, suspends payment under that section.

1307 SUSPENSION OF MEDICAID PAYMENTS FOR OVERPAYMENT-EVIDENCE AND NOTICE

1307.1 When the provider, pursuant to §1306, submits a statement, the Director shall consider the statement including any pertinent evidence submitted together with any other material bearing upon the case and shall make a determination as to whether the facts justify a suspension.

1307.2 If the Director determines that a suspension shall go into effect, a written notice of the detemination shall be sent to the provider.

1307.3 The notice shall contain specific findings on the conditions upon which the suspension was based and an explanatory statement for the final decision.

1307.4 The suspension shall not take effect for at least fifteen (15) days following the date of the notice.

1307.5 If the provider requests a hearing by filing a notice of appeal from the determination of suspension and overpayment with the D.C. Board of Appeals and Review within the fifteen (15) day period, the suspension shall not take effect until after a final decision is rendered following a hearing under these rules.

1307.6 A request for a hearing to appeal the Director's decision to suspend shall not stay the effectiveness of the suspension, if the Director determines that there is reasonable cause to believe that the provider will not refund overpayments other than through offset of program payments by suspension.

1307.7 The Director's implemention of a suspension, in whole or in part, does not in any way abrogate the right of the provider to file an appeal with the D.C. Board of Appeals and Review and to have a final decision rendered before final liability is established.

1307.8 The provider has fifteen (15) days from the date of the notice sent, pursuant to §1307.4, to request a hearing by filing a notice of appeal.

1308 SUBSEQUENT ACTION BY THE DIRECTOR

1308.1 When a suspension is put into effect by reason of §1306.2, the suspension shall remain in effect until one (1) of the following occurs:

(a) The overpayment is liquidated;

1308 SUBSEQUENT ACTION BY THE DIRECTOR (Continued)

1308.1 (Continued)

(b) The Director enters into an agreement with the provider for liquidation of the overpayment, subject to approval by the Office of the Corporation Counsel; or

(c) The Director or the D.C. Board of Appeals and Review determines that there is no overpayment.

1308.2 When the suspension is put into effect in accordance with §1306.3, the Director shall take timely action after the suspension to obtain the additional evidence as may be needed to make a determination regarding whether an overpayment exists or that payments were correct. All reasonable efforts shall be made by the Director to expedite the determinations.

1308.3 The provider shall be immediately informed of the determination by the Director under §1308.2 and, where appropriate, suspension shall be rescinded or adjusted to take into account the determination.

1308.4 If the suspension is not rescinded, it shall remain in effect as specified in §1308.1.

1308.5 Nothing in this chapter shall prohibit the Director from recovering overpayments through referral of the case to the Office of the Corporation Counsel for appropriate legal action.

1308.6 Nothing in this chapter authorizes any DHS official to compromise any claim with respect to a provider under the Medicaid Program.

1309 PROCEDURES REGARDING DETERMINATION OF PROGRAM REIMBURSEMENT BASED UPON COST REPORTS

1309.1 The procedures contained in this section through §1311 govern DHS determinations of Medicaid program reimbursement due to those Medicaid providers who are reimbursed based upon cost reports filed by the providers.

1309.2 Upon receipt of a provider's cost report, the Director shall, within a reasonable period of time, analyze the report and furnish the provider a written notice reflecting the determination of the amount of program reimbursement due to the provider. The notice shall include the following:

(a) Explain the Department's detemination of total program reimbursement due the provider for the reporting period covered by the cost report or amended report;

1309 PROCEDURES REGARDING DETERMINATION OF PROGRAM REIMBURSEMENT BASED UPON COST REPORTS

1309.2 (Continued)

(b) Relate this determination to the provider's claimed total program reimbursement due for the reporting period;

(c) Explain the amount of the program reimbursement;

(d) Explain the reason why, by appropriate reference to law, regulations, or program manual, the determination differs from the provider's claim; and

(e) Inform the provider of his or her right to a hearing and that the hearing shall be requested within thirty (30) days after the date of notice.

1309.3 The determination, as contained in a notice of amount of program reimbursement, shall constitute a basis for making the retroactive adjustments to any program payments made to the provider during the period to which the determination applies.

1309.4 The determination shall also include the suspension of further payments, in whole or in part, to the provider in order to recover or to aid in the recovery of any overpayments identified in the determination to have been made to the provider, notwithstanding any request for a hearing on the determination the provider may make.

1309.5 The suspension shall remain in effect as specified in §1308 of this chapter.

1310 EFFECT OF DIRECTOR'S DETERMINATION

1310.1 The determination by the Director shall be final and binding on the provider submitting a cost report for program reimbursement unless either of the following occurs:

(a) The Director revises his or her determination on the basis of additional documentation; or

(b) The provider requests a hearing and a decision is rendered.

1311 RIGHT TO A HEARING

1311.1 The provider who has been furnished a notice of amount of program reimbursement may request a hearing, if he or she is dissatisfied with the Director's determination contained in the notice, by filing a notice of appeal with the D.C. Board of Appeals and Review.

1311.2 The request for a hearing shall be in writing and filed with the Board within thirty (30) days after the date of the notice of program reimbursement.

1312 NOTICE OF SANCTIONS TO OTHER PARTIES

1312.1 When a provider has been excluded, terminated or suspended pursuant to §1304, the Director shall notify the following parties regarding any action taken and the effective date:

(a) HCFA; and

(b) The following, as appropriate:

(1) Members of the public;

(2) Recipients;

(3) Professional Standard Review Organizations;

(4) Other providers and organizations;

(5) Medical societies and professional organizations;

(6) State and District licensing boards and affected state and District agencies and organization; and

(7) Medicare carriers and intermediaries.

1313 HEARING PROCEDURES

1313.1 All hearings shall be conducted before the D.C. Board of Appeals and Review in accordance with its Rules of Practice and Procedure, Title 1 DCMR.

1314 REINSTATEMENT TIMING AND METHOD OF REQUEST FOR REINSTATEMENT

1314.1 This section governs requests for reinstatement in the District's Medicaid Program that are submitted by any one (1) of the following:

(a) A party who has been excluded from the program for fraud and/or abuse;

(b) A party suspended from participation for conviction of program-related crimes; or

(c) A party terminated from the program.

1314.2 In order to establish the earliest date upon which the Director may consider a request for reinstatement of a party who has been excluded from participation in the program, the Director shall consider the following:

(a) The number and nature of the program violations and other related offenses;

(b) The nature and extent of any adverse impact the violations have had on recipients;

(c) The amount of any damages;

(d) Whether there are any mitigating circumstances; and

(e) Any other facts bearing on the nature and seriousness of the program violations or related offenses.

1314.3 A party may request reinstatement in the District's Medicaid Program by filing a request in writing, with the Director, after the date specified in the notice of exclusion or suspension setting forth reasons why he or she should be reinstated.

1314.4 The person shall submit or authorize the Director to obtain the following items:

(a) Statements from peer review bodies, probation officers, where appropriate, or professional associates as required by the Director, attesting to their belief and supported by facts, that the violations which led to the exclusion or conviction shall not be repeated; and

(b) Statements from private health insurers indicating whether there have been any questionable claims submitted during the period of exclusion or suspension.

1314.5 The Director shall not reinstate a party that has been suspended from Medicare or suspended at the direction of HCFA or until HCFA notifies the Director that the party may be reinstated.

1314.6 If HCFA notifies the Director that it has reinstated a party under Medicare, the Director shall automatically reinstate the party in the District's Medicaid Program, effective on the date of reinstatement under Medicare, unless the Director has imposed an administrative sanction against the party under these rules.

1314.7 When a provider agreement has been terminated in accordance with this chapter, the Director shall not accept a new agreement from that party unless the following conditions are met:

(a) The Director finds that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) The Director finds that the party has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

1315 ACTION ON REQUEST FOR REINSTATEMENT

1315.1 The Director may grant reinstatement to a provider that has been excluded only if he or she is reasonably certain that the violation that led to the exclusion will not be repeated.

1315.2 In making this determination, the Director shall consider, among other factors, the following:

(a) Whether the party has been convicted in a Federal, State or local court of other offenses related to participation in the Medicare or Medicaid Program which were not considered during the development of the exclusion; and

(b) Whether the State of local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid Programs which were not considered during the development of the exclusion.

1315.3 If the Director approves a request for reinstatement, he or she shall give written notice to the excluded, terminated or suspended party and to all others who were informed under §1312 specifying the date on which the Medicaid Program partipation shall resume.

1315.4 If the Director does not approve the request for reinstatement, he or she shall notify the party in writing of the decision.

1316 APPEAL

1316.1 A provider may request a hearing on action taken by the Director on the provider's request for reinstatement by filing a notice of appeal with the D.C. Board of Appeals and Review pursuant to the rules of the Board.

1399 DEFINITIONS

1399.1 For purposes of this chapter, the following terms shall have the meanings ascribed:

Abuse - the provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the program or in reimbursements for services that are not medically necessary or do not meet professionally recognized standards for health care. Abuse is characterized by, but not limited to, the presence of one (1) of the following conditions:

(a) The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include, but are not limited to, incorrect or missing procedure or diagnosis codes, incorrect mathemetical entries, and incorrect third party liability information;

(b) The repeated submission of claims by a provider which overstate the level or amount of health care provided;

(c) The repeated submission of claims by a provider for health care which is not reimbursable under the program, or the repeated submission of duplicate claims;

(d) Failure of a provider to develop and maintain patient care records which document the nature, extent, and evidence of the medical necessity of health care provided;

(e) Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate entries on the medical or health care records to corresponding entries on the billing invoice, unless otherwise indicated by federal or District law or rules; or

(f) The repeated submission of claims by a provider for health care which is not medically necessary, of which is of unacceptable quality.

DHS - the Department of Human Services.

1399.1 (Continued)

Director - the Director of the Department of Human Services.

Fraud - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under the laws of the District of Columbia, Federal or State law.

HCFA - the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Provider - an individual or entity furnishing Medicaid services under a provider agreement with DHS.